Speech Language Pathology

Definition: Speech-Language Pathology is available through the MR/RD Waiver as an extension to the services included in the State's Medicaid Program Plan. Through the State Plan, services are available to recipients who are under age 21. The MR/RD Waiver removes the age limit restriction, making the same services available to recipients who are over age 21 and enrolled in the MR/RD Waiver. Therefore, the MR/RD Waiver cannot provide Speech Therapy for children under the age of 21. [If a child needs additional Speech Therapy that is not being provided by their school, then authorization can be obtained from a physician for additional Speech Therapy **if** it is addressing different goals from the school **and** is being provided on different days of the week. This would be funded through State Plan Medicaid and would not be an MR/RD Waiver Service].

Speech-Language Pathology services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatment are not indicated. Services include preventing, evaluating, and treating disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition/communication, auditory and/or visual processing and memory, and interactive communication, as well as the use of augmentative communication systems (sign language, gesture systems, communication boards, electronic automated devices, mechanical devices) when appropriate.

These services include but are not limited to:

- Speech evaluation (one per lifetime)
- Speech re-evaluation (up to 2 every 12 months)
- Individual therapy (up to 2 - 30 minute units per day)

Providers: Speech-Language Pathology services are to be provided by Speech-Language Pathologists who are licensed in South Carolina and enrolled with SCDHHS to provide Medicaid funded Speech-Language Pathology Services.

Arranging for the Services: Through your assessment of the recipient, you may determine the need for an evaluation of his/her speech-language abilities. This need must be clearly documented in the Plan. The recipient or his/her family should be given a listing of available providers and allowed to select a provider from the listing. This offering of choice of provider must be documented in the recipient's file.

Once a provider is chosen, the Waiver Tracking System must be updated to reflect the addition of the evaluation or re-evaluation (S41-one unit equals one evaluation). Once approved Speech-Language Pathology Services Evaluation can be authorized using the **Authorization for Services MR/RD Form A-19 or A-20**. For recipients receiving MR/RD Waiver funded Residential Habilitation, Day Habilitation, Prevocational Habilitation, or Supported Employment, Speech-Language Pathology Services Evaluation must be authorized using the **MR/RD Form A-20** which instructs the provider to bill the DSN Board for services rendered.

The **MR/RD Form A-19** must be used for all other recipients. The **MR/RD Form A-19** instructs the provider to bill Medicaid for services rendered.

The provision of this specific service must be monitored. Once provided, the results of the evaluation/re-evaluation should be obtained and reviewed. The evaluation/re-evaluation results will determine the need for any other Speech-Language Pathology services such as therapy.

If therapy is needed, the Plan must be updated to reflect the need, the frequency and the amount to be provided. The recipient must again be offered a choice of provider and the offering of choice must be documented. The Waiver Tracking System must be updated to reflect the need for therapy (S16-one unit equals 30 minutes of services). **The Authorization for Services MR/RD Form A-19 and A-20** must be used to authorize the service as previously noted.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Speech Therapy Evaluations and Services.

Speech Therapy Evaluation

- Within two weeks of completion

Monitorship of this service should occur with the individual/family and the service provider. Monitorship must include review of the evaluation report and notes completed by the provider. Some items to consider during monitorship include:

→ What are the recommendations from the evaluation?
→ If therapy is being recommended, is the person expected to increase his/her functional level or are the recommendations aimed at maintenance activities?
→ Was any equipment recommended?
→ If therapy is being recommended, what amount is needed and how often?

Speech Therapy

- At least monthly for the first two months
- At least quarterly thereafter
- Conversation with recipient or family/caregiver at least every six months
- Start over with each new provider

Monitorship of this service may occur with the individual/family or service provider. Monitorship may also occur during review of evaluation reports or progress notes completed by the provider. Some items to consider during monitorship include:

→ Are the types of activities specified in the evaluation being completed with the individual?
→ Are the goals and objectives of therapy consistent with the individual's overall life goals?

- → Is the individual satisfied with his/her current therapy?
- → Does he/she feel that the provider is responsive to his/her needs?
- → Does he/she feel that there is a good relationship with the therapist?
- → Does the individual appear to be making significant progress towards the goals and objectives outlined in therapy? Are the goals and objectives amended, as the individual's needs change?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

Speech/Language Pathology

_____ Evaluation _____ Re-evaluation

_____ Therapy Start Date _____

Total Number of Units Per Week to be Provided: _____ (one unit = 30 minutes)

_____ Consultation

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-19 (1/05)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Speech/Language Pathology

_____ Evaluation _____ Re-evaluation

_____ Therapy Start Date _____

Total Number of Units Per Week to be Provided:_____ (one unit = 30 minutes)

_____ Consultation

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-20 (8/01)